	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
		155816	B. WING		03/26/2015	
	PROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE IAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 000 Bldg. 00	State Licensure included the Inv IN00168899.  Complaint IN00 Federal/State de allegations are c Survey dates: M 26, 2015.  Facility number: Provider number AIM number: 20 Survey team: Beth Walsh, RN	arch 19, 20, 23, 24, 25, & 013005 r: 155816 01256400 -TC eneralist (March 24, 25, th, RN	F 000			
	iviculcate. 31					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

013005

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Facility ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. B	UILDING	00	COMPL	ETED		
		155816	B. W	TING		03/26	/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	cited in accordar	es reflect state findings nce with 410 IAC						
	16.2-3.1.  Quality review c 2014, by Cheryl	completed on April 2, Fielden, RN.						
F 280 SS=D Bldg. 00	CARE-REVISE CI The resident has to incompetent or oth incapacitated undeparticipate in plant changes in care at A comprehensive developed within of the comprehensity by an interdiscipling the attending physical with responsibility appropriate staff in	CIPATE PLANNING P the right, unless adjudged herwise found to be er the laws of the State, to ning care and treatment or						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
	155816	B. WING 03/26/2015		
		CTDEET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		ARLINGTON AVE	
ADLING	TON DI ACE HEALTH CAMPILE		IAPOLIS, IN 46218	
ARLING	TON PLACE HEALTH CAMPUS	INDIAN	1APOLIS, IN 46216	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	practicable, the participation of the resident,			
	the resident's family or the resident's legal			
	representative; and periodically reviewed			
	and revised by a team of qualified persons			
	after each assessment.	F 200	F 200 Composting actions	0.4/0.5/0.01.5
		F 280	F 280 Corrective actions	04/25/2015
	Based on observation, interview, and		accomplished for those residents found to be affecte	
	record review, the facility failed to update		by the alleged deficient	a
	a resident's care plan regarding the		practice: Resident #2 care p	lan
	resident's preference to remain in bed for		interventions were reviewed a	
	1 of 22 residents reviewed for care plans. (Resident #2)		updated related to the residen	
			preference to remain in bed	
			frequently. Identification of	of
			other residents having the	
	Findings include:		potential to be affected by th	e
			same alleged deficient practi	III
	Resident #2's record was reviewed on		and corrective actions taken	
	3/23/15 at 1:49 p.m. The resident's		DHS or designee will review a	
	diagnoses included, but were not limited		update all care plan intervention	III
			related to the following: reside	ent's
	to, Type 1 diabetes, hypertension,		preference to remain in bed.	
	congestive heart failure, coronary artery		Measures put in place and	
	disease, hyperlipidemia, neuropathy,		systemic changes made to ensure the alleged deficient	
	stage IV kidney disease, and a history of		practice does not recur: DHS	Sor
	stroke and heart attack.		designee will re-educate the	, 01
			Interdisciplinary Care Plan Tea	am
	A 2/1/15 MDS (Minimum Data Set)		on the following guidelines:	
	assessment indicated Resident #2 had a		Interdisciplinary Team Care Pl	an
			How the corrective measures	<b>;</b>
	BIMS (Brief Interview for Mental Status)		will be monitored to ensure t	he
	score of 13 which indicated the resident		alleged deficient practice do	
	did not have a severe cognitive		not recur: The following audit	3
	impairment.		and /or observations for 5	
			residents per unit will be	
	On 3/23/15 at 2:35 p.m., during an		conducted by the DHS or	
	_		designee 2 times per week times	
	observation, Resident #2 was lying in a		8 weeks, then monthly times 4 months to ensure compliance:	
	bed in his room.		Review of care plan to ensure	1.
			l to view of care plan to ensure	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE ( COMPL 03/26/	ETED
	PROVIDER OR SUPPLIER			1635 N A	DDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observation, Resbed in his room a nearby.  On 3/25/15 at 9: interview, LPN # "very rarely" get his preference ar staff attempts to She did not know preference to represident's care plotted on 3/25/15 at 9:: interview, CNA "might get out or indicated it was at to stay in bed. He frequently declinassist him to get  On 3/25/15 at 9:: interview, the DI Services) indicate frequently refuse his admission to She indicated state the resident to get frequently refuse bed."	hain in bed was in the an.  26 a.m., during an #2 indicated Resident #2 feed once a month" and the resident's preference the indicated the resident hed staff attempts to out of bed.  42 a.m., during an HS (Director of Health hed Resident #2 had hed to get out of bed since the facility on 12/2/14. Iff would offer to assist het out of bed daily, but he hed as he "liked to be in			interventions for resident's preference to remain in bed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee a minimum of 6 months then randomly thereafter for further recommendation.		
		58 a.m., during an HS indicated Resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155816	B. WING 03/26/2015				2015
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
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F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUE CARE PLAN The services provifacility must be propersons in accords written plan of care Based on interviethe facility failed anticoagulation rordered for 1 of sunnecessary mediunecessary mediunecess	ew and record review, I to administer medication and insulin as 5 residents reviewed for lication. (Resident #52) : al record for Resident d on 3/26/15, at 9:30 ses for Resident #52 re not limited to, right	F 28	32	F 282  Corrective actions accomplished for those residents found to be affecte by the alleged deficient practice: Resident #52 MAR reviewed to ensure any anticoagulant medication and sliding scale insulin is administered/documented as ordered.	d	04/25/2015

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A BUILDING 155816  NAME OF PROVIDER OR SUPPLIER  ARLINGTON PLACE HEALTH CAMPUS  INDIANAPOLIS, IN 46218  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  The March, 2015 Physician's Orders indicated 30 mg of Lovenox (anticoagulation medication) to be given to Resident #52 subcutaneously (under the skin), by injection, daily after rising.  The 3/12/15 Orthopedic Physician Note for Resident #52 indicated for the Lovenox to be continued for 1 more week.  The 3/12/15 Physician Telephone Order indicated to discontinue the Lovenox on 3/19/15.
NAME OF PROVIDER OR SUPPLIER  ARLINGTON PLACE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  The March, 2015 Physician's Orders indicated 30 mg of Lovenox (anticoagulation medication) to be given to Resident #52 subcutaneously (under the skin), by injection, daily after rising.  The 3/12/15 Orthopedic Physician Note for Resident #52 indicated for the Lovenox to be continued for 1 more week.  The 3/12/15 Physician Telephone Order indicated to discontinue the Lovenox on  The 3/12/15 Physician Telephone Order indicated to discontinue the Lovenox on  STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE 1635 N ARLINGTON AVE 1625 N ARLINGTON AVE 1635 N ARLINGTON AVE 1635 N ARLINGTON AVE 1625 N ARLINGTON AVE 1635 N ARLINGTON AVE 1621 N 46218   (X5)  COMPLETION 1624 CORSECTIVE ACTION SIOULE BE 1625 CORSECTIVE ACTION SIOULE BE 1626 CORSECTIVE ACTIO
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indicated to discontinue the Lovenox on of the blood sugar reading as
The March, 2015 MAR (medication
through 3/19/15, as ordered.  ensure the alleged deficient practice does not recur: DHS or
designee will re-educate the
An interview was conducted with the Licensed Nurses on the following
ADHS (Assistant Director of Health guidelines: 1. Specific
Services) on 3/26/15, at 10:55 a.m. She
indicated she did not know what Procedures 2. Blood Sugar
happened in regards to the Lovenox, but
the physician would be informed  How the corrective measures
Resident #52 was not given the Lovenox will be monitored to ensure the
as ordered.  will be intollicated to ensure the
not recur: The following audits
and /or observations for 5
An interview was conducted with LPN residents per unit will be
#7 on 3/26/15, at 12:51 p.m. She conducted by the DHS or
indicated she worked on 3/14/15, designee 2 times per week times
3/15/15, and 3/16/15. She indicated she
administered Resident #52's other months to ensure compliance: 1.  Anticoagulant medication is

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NAME OF F	PROVIDER OR SUPPLIER	t.		1635 N	ARLINGTON AVE		
ARLING1	TON PLACE HEALT	TH CAMPUS			APOLIS, IN 46218		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES	1	ID	· 	(X5)	
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TAG	`	LSC IDENTIFYING INFORMATION)				DATE	
	morning medica	· · · · · · · · · · · · · · · · · · ·			being administered/document		
		ovenox any of those			as ordered 2. Sliding scale		
		ovenox any of those		insulin is being administered /			
	days.				documented on the MAR		
					according to the results of the		
		2015 Physician's Orders			blood sugar reading as ordere	d.	
	for Resident #52	indicated Novolog					
	(insulin) to be ac	lministered sliding scale					
	for the following	g blood sugar readings:					
	131-150=1 Unit, 151-250=2 Units, 251-300=3 Units, 301-350=4 Units,						
					The results of the audit		
	351-400=5 Units	s, and over 400=6 Units.			observations will be reported, reviewed and trended for		
					compliance thru the campus		
	The March, 2015 MAR for Resident #52 indicated the following blood sugar				Quality Assurance Committee	for	
					a minimum of 6 months then		
		its of insulin given for			randomly thereafter for further		
	those readings:	its of mouning even for			recommendation.		
	mose readings.						
	2/1/15 before his	nch: 148, no insulin					
		icii. 148, ilo ilisuilii					
	given	1.0 / 120 1:					
		eakfast: 138, no insulin					
	given						
		nch: 80, 3 Units given					
		nch: 153, 3 Units given					
		unch: 104, 3 Units given					
	3/16/15 before lu	unch: 131- no insulin					
	given						
	3/20/15 before d	inner: 232, (Units					
	section was blan	k)					
	3/21/15 before lu	unch: 140, 3 Units given					
	An interview wa	s conducted with the					
	ADHS on 3/26/1						
		correct amounts of					
		the above blood sugar					
	111341111 51 VCII 101	and above brood sugar				1	

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		155816	B. W.	ING		03/26/	2015	
NAME OF F	PROVIDER OR SUPPLIER	-		STREET A	DDRESS, CITY, STATE, ZIP CODE			
					ARLINGTON AVE			
ARLINGTON PLACE HEALTH CAMPUS				INDIAN	APOLIS, IN 46218			
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		dicated, "There's						
	obviously a prob	olem here."						
		Care Plan for Resident						
	#52 indicated, "A	Administer my insulin as						
	orderedMy go	al is to have no diabetic						
	stress."							
	The Medication	Administration Policy						
	was provided by	the Clinical Support						
	Clinician on 3/20	6/15, at 12:28 p.m. It						
	indicated, "Medi	cations are administered						
	as prescribed in	accordance with good						
	nursing principle	es and						
		cations are administered						
		ith written orders of the						
		ianThe individual who						
		nedication dose records						
		on on the resident's MAR						
		medication is given. At						
	1	nedication pass, the						
		ering the medications						
	1 ^	R to ensure necessary						
	doses were admi	_						
		no case should the						
	individual who a							
		ort off duty without first						
		ministration of any						
	medications."	ininistration of any						
	medications.							
	3.1-35(g)(2)							
F 314	492.25(c)							
SS=D	483.25(c) TREATMENT/SV	CS TO PREVENT/HEAL						
Bldg. 00	PRESSURE SOR							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Z6PX11

Facility ID: 013005

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STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155816 B. WING 03/26/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1635 N ARLINGTON AVE ARLINGTON PLACE HEALTH CAMPUS INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Corrective actions** F 314 04/25/2015 Based on interview and record review, accomplished for those the facility failed to timely address a residents found to be affected resident's skin conditions, after by the alleged deficient recognition upon admission, for 1 of 3 practice: Resident #D was residents reviewed for pressure ulcers. discharged from the campus. Identification of other residents (Resident #D) having the potential to be affected by the same alleged Findings include: deficient practice and corrective actions taken: The clinical record for Resident #D was Review of all residents who currently have skin impairment to reviewed on 3/25/15, at 9:30 a.m. The ensure the skin condition is diagnoses for Resident #D included, but re-assessed in a timely manner, a were not limited to, stage 2 pressure ulcer treatment and interventions are in left heel and stage 2 pressure ulcer right Measures put in place and systemic changes made to heel. ensure the alleged deficient practice does not recur: DHS or The 10/24/15 Nursing Admission designee will re-educate the Assessment & Data Collection form Licensed Nurses on the following indicated Resident #D had an intact campus guidelines: General Wound and Skin Care How the blister on his left heel, measuring 2.8 cm corrective measures will be X 3.4 cm. It described his right heel as monitored to ensure the "dark, red, smooshy". The Skin Plan of alleged deficient practice does Care indicated on the form was to turn not recur: The following audits and reposition for comfort and with care; and /or observations for 5 residents per unit will be prevent skin from touching skin; elevate

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Facility ID: 013005

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G 00	(X3) DATE COMPI 03/26	LETED
	PROVIDER OR SUPPLIER		163	EET ADDRESS, CITY, STATE, ZIP CODE 5 N ARLINGTON AVE IANAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	on Be PRIATE	(X5) COMPLETION DATE
	relieving device assist with positi The tool indicate 1 wound or great 1 wound or great The 11/10/15 Proform for Resider the initial identificant on 11/10/15. It is and measured 2 of There was no Proform for Resider The 11/11/15 Wound as a ruptured be 1.5 cm x 1 cm x prep for treatment the right heel words 2, measured 1 cm had skin prep for no wound trackin #D's pressure ulder prior to 11/11/15 An interview was DHS (Director of the ADHS (Assistant) Services), who a Wound Nurse, of The DHS indicate 10/24/15 Nursing 11/10/15 Proformed Proforme	essure Ulcer Assessment at #D's left heel indicated fication of the wound was indicated it was a stage 2 cm x 2 cm x 0.1 cm. essure Ulcer Assessment at #D's right heel.  found Tracking form at #D's left heel wound lister, stage 2, measured found to measured found was a blister, stage at x 1 cm x 0.1 cm, and at treatment. There were ang forms for Resident forms in the clinical record		conducted by the DHS or designee 2 times per week 8 weeks, then monthly time months to ensure compliar Review of residents with skimpairment to ensure the scondition is re-assessed in timely manner, a treatment interventions are in place. The results of the audit observations will be reportereviewed and trended for compliance thru the campu Quality Assurance Commit a minimum of 6 months the randomly thereafter for furt recommendation.	es 4 ce: in kin a and ed, s dee for n	

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Event ID:

Z6PX11

Facility ID: 013005

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE COI JILDING	NSTRUCTION 00	COMPL		
11112 12111	or continue from	155816	B. W		00	03/26/	
	ROVIDER OR SUPPLIER ON PLACE HEALT SUMMARY S'		1 2. 11	STREET A	DDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218  PROVIDER'S PLAN OF CORRECTION	03/20/	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	of 10/25/15, at w mattress would him. The DHS is left heel, found of 2 pressure ulcer. Nurse/ADHS incompleted to track and put Resident would have put a and put Resident would have put a and put Resident would rounds. Nurse/ADHS incompleted to track and put Resident #D's rige effective 11/11/11 about his right his 10/24/14 adm started the skin put and the started the skin put and put Resident #D, after admission.	which point, a low air loss have been put in place for indicated the blister to his on admission, was a stage. The Wound dicated she was not told to Resident #D's left heel and had she known prior, a treatment order in place if #D on her weekly. The Wound dicated a low air loss put in place for Resident 5. The Wound dicated the skin prep to ght heel was put in place 5, but had she known eel skin impairment upon mission, would have brep sooner.		TAG	DEFICIENCY)		DATE
	general wound a	nd skin care guidelines					

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PRINTED: 04/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155816		(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE : COMPL 03/26/	ETED	
	ROVIDER OR SUPPLIER			1635 N <i>A</i>	DDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F 329 SS=D Bldg. 00	potential and/or a integrity20. Decation, stage (in width, depth (in periwound tissue wound weekly used treatment flow stage II-IV press any questions."  This Federal tage IN00168899.  3.1-40(a)(2)  483.25(I) DRUG REGIMEN UNNECESSARY If Each resident's draw from unnecessary drug is any drug weekled does (including duexcessive duration monitoring; or with for its use; or in the consequences who should be reduced combinations of the Based on a compart resident, the facilitate residents who have drugs are not give antipsychotic drug treat a specific condocumented in the consequence of the specific condocumented in th	DRUGS  ug regimen must be free drugs. An unnecessary when used in excessive plicate therapy); or for n; or without adequate lout adequate indications e presence of adverse ich indicate the dose I or discontinued; or any					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETI			ETED
		155816	B. W	B. WING 03/26/2015			2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R					
ARI INGT	ON PLACE HEALT	TH CAMPUS		1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218			
					1		
(X4) ID		TATEMENT OF DEFICIENCIES	IID  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL			TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	_	ose reductions, and					
	behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  Based on interview and record review, the facility failed to ensure residents were						
			F 32	29			04/25/2015
					F 329		
	•	nature or intensity of					
		o administration,					
	non-pharmacological interventions were tried prior to administration, and for the effectiveness of the medication after the administrations of PRN (as needed) pain medication for 2 of 5 residents reviewed				Corrective actions		
					accomplished for those residents found to be affecte	ч	
					by the alleged deficient	u	
					practice: Resident #E has be	en	
					discharged from the campus.	011	
	for unnecessary	medication and 1 of 3			Res #104 and #6 - review PRI	N	
	residents review	ed for accidents.			tracking sheet to ensure		
	(Resident #'s E,	104, 6)			documentation is in place that		
	,	, ,			residents are assessed for the		
	Findings include	··			nature or intensity of their pair prior to administration,	ı	
	i mamgs merade	·•			non-pharmacological		
	1 The clinical r	record for Resident #E			interventions were tried prior to	0	
					administration, and for the		
		n 3/24/15, at 9:30 a.m.			effectiveness of the medicatio		
	_	or Resident #E included,			after the administration of a PI	≺N	
		ited to, C1 cervical			pain medication.		
	fracture.				Identification of other reside	nts	
					having the potential to be		
	The 1/18/15 hos	pital records for Resident			affected by the same alleged		
	#E indicated, "C	linical Impression: 1.			deficient practice and		
	Compression fra	ecture of C-spine 2.			corrective actions taken: DH	IS	
	Traumatic hema	_			or designee will review the		
	Multiple abrasio	nsDischarge:follow			following: All residents with a		
	•	d with Arlington Place,			order for PRN pain medication ensure documentation is in pla		
	•	nurse), prescriptions for			that they are assessed for the		
	,				nature or intensity of their pair		
	Norco (pain med	iicauon) given.			prior to administration,		
	m 4/42/2				non-pharmacological		
	L The 1/18/15 Phy	vsician Telephone Order	- 1		Interventions were tried prior to	^	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155816	B. W	ING		03/26/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ARLINGTON AVE	
ARLINGT	TON PLACE HEALT	TH CAMPUS			APOLIS, IN 46218	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated one 5-3	325 mg tablet of			administration, and for the	
	hydrocodone (pa	in medication) to be			effectiveness of the medication after the administration of a PF	
	given every 6 ho	urs, as needed, for pain			pain medication.	NN
	due to Resident #	E's cervical fracture.			pain medication.	
	The January 201	15 MAR (medication				
	<u>-</u>	ecord) for Resident #E			Measures put in place and	
	indicated he was	· · · · · · · · · · · · · · · · · · ·			systemic changes made to	
					ensure the alleged deficient	
	hydrocodone on the following dates and times: 1/20/15 at 8:30 a.m., 1/21/15 at 3:00 p.m., 1/22/15 at 9:00 p.m., 1/24/15				practice does not recur: DHS designee will re-educate the	or
					Licensed Nurses on the follow	ina
					campus guidelines: 1).	9
	`	ented), 1/28/15 at 8:00			Administration of PRN	
	p.m., and 1/30/1:	5 (no time documented).			Medications 2). PRN Medicat	ion
	There was no inf	Formation in the clinical			Tracking Log	
	record to indicate	e Resident #E was				
	assessed for the	nature or intensity of his				
	pain prior to adm	•			How the corrective measure	
		gical interventions were			will be monitored to ensure t	-
		ninistration, or for the			alleged deficient practice doe	
	•	the medication after the			not recur: The following audits	3
	administrations.	the inedication after the			for 5 residents per unit will be	
	administrations.				conducted by the DHS or	
					designee 2 times per week times	
		s conducted with the			8 weeks, then monthly times 4 months to ensure compliance:	
	,	f Health Services on			Review of residents with an or	der
	3/24/15, at 12:37	-			for / received PRN pain	
	acknowledged a	lack of verification in			medication to ensure	
	the clinical recor	d for the assessment of			documentation is in place that	
	Resident #E's pa	in prior to and after the			they are assessed for the natu	
	above prn pain n	-			or intensity of their pain prior to administration,	)
		She indicated Resident			non-pharmacological	
		retty bad" when he			interventions were tried prior to	,
		e hospital on 1/18/15.			administration, and for the	
		ecord for Resident #104			effectiveness of the medication	
					after the administration of a PF	₹N
	was reviewed on	3/23/15 at 1:45 p.m.	- 1		pain medication.	l l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155816	B. W	ING		03/26/2015
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			1635 N	ARLINGTON AVE	
	TON PLACE HEALT			INDIAN	APOLIS, IN 46218	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY	DATE
	The diagnoses for					
	· · · · · · · · · · · · · · · · · · ·	re not limited to, muscle				
	· ·	ic obstructive pulmonary				
	disease, hypoxer	nia, and dyspnea.				
	The December 2	014 Physician's Orders				
		er for Norco (narcotic			The results of the audit	
		,			observations will be reported,	
	1 *	325 mg (milligrams) to every 4 hours as needed			reviewed and trended for compliance thru the campus	
		every 4 nours as needed			Quality Assurance Committee	for
	(PRN).				a minimum of 6 months then	
					randomly thereafter for further	
		014 MAR (medication			recommendation.	
	administration re	ecord) indicated Norco				
	was given on the	e following days:				
	12/1/14 (time inc	decipherable),				
	12/2/14 (time inc	decipherable),				
	12/7/14 (11:00 a	.m.),				
	12/8/14 (11:00 p					
	12/17/14 (10:30	· ·				
	12/19/14 (10:00					
	12/22/14 (11:00	1 //				
	12/23/14 (10:00	* /:				
	12/26/14 (time in	* /:				
	12/20/14 (time ii 12/27/14 (time ii	*				
	`	* ''				
	12/28/14 (time in	* ''				
	`	ndecipherable), &				
	12/31/14 (time ii	naecipherable)				
	 There was no int	formation in the clinical				
		e Resident #104 was				
		nature or intensity of her				
	pain prior to adn	_				
	_	gical interventions were				
	tried prior to adn	ninistration, or for the				

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Facility ID: 013005

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPL A. BUILDIN B. WING		od	(X3) DATE : COMPL 03/26/	ETED
	PROVIDER OR SUPPLIER		163	5 N A	DRESS, CITY, STATE, ZIP CODE RLINGTON AVE POLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	effectiveness of administrations of	the medication after the of PRN Norco.					
	but was current a indicated an inte	nent Care Plan, no date at the time of review, rvention to monitor for of the pain medication.					
	Health Services 2:13 p.m., she in supposed to doct the PRN pain me	iew with the Director of (DHS), on 3/23/15 at dicated nursing staff was ament the necessity for edication and the the PRN pain medication					
	indicated she wa documentation re above PRN pain effectiveness of administered. The the purpose of do administration of was to ensure the adequately contri	s unable to locate egarding the need for the medication and the the PRN pain medication he DHS further indicated ocumenting/tracking f PRN pain medication e pain was being olled and to determine if trent pain issue for a					
	was reviewed on The diagnoses for but were not lim	ecord for Resident #6 3/24/15 at 1:45 p.m. or Resident #6 included, ited to, diabetes mellitus, ion, and Parkinson's					

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Facility ID: 013005

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) M	(X2) MULTIPLE CONSTRUCTION (X			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155816	B. W	ING		03/26/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	8			ARLINGTON AVE		
ARLINGTON PLACE HEALTH CAMPUS				APOLIS, IN 46218			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	disease.						
	The February 20	115 Physician's Orders					
	indicated an order for Ultram (opioid						
	pain reliever) 50	mg (milligrams) to be					
	administered as	needed (PRN) for pain.					
	The February 20	015 MAR (medication					
	_	ecord) indicated PRN					
		en on the following days:					
	2/4/15 (2:00 p.m						
	2/7/15 (3:00 a.m						
	2/8/15 (1:00 p.m						
	2/28/15 (4:00 p.n						
	2/28/13 (4.00 p.)	III. <i>)</i> .					
	T1	Comments of the allocations					
		formation in the clinical					
		e Resident #6 was					
		nature or intensity of her					
	pain prior to adn	· ·					
	•	gical interventions were					
	tried prior to adr	ministration, or for the					
	effectiveness of	the medication after the					
	administrations	of PRN Ultram.					
	During an interv	riew with the Director of					
	Health Services	(DHS), on 3/25/15 at					
	3:20 p.m., the D	HS indicated she was					
	•	documentation regarding					
	the need for the						
		the effectiveness of the					
		eation administered.					
	Tier pain medic	auon aummisteleu.					
	A policy titled	Administration of PRN					
	Medication Guid	deline, no date, was					

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Facility ID: 013005

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155816  A. BUILDING  00  B. WING			COMPLETED 03/26/2015			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	9:10 a.m. The po Documentation s for administering i.e.: c/o [complai headache,wring hip pain5. Fol	ging hands, c/o of [sic] llow up should be noted ectiveness and/or assess					
R 000 Bldg. 00 R 217 Bldg. 00	accordance with  410 IAC 16.2-5-2( Evaluation - Defici (e) Following comp	e)(1-5) ency oletion of an evaluation,	R 000				
	members, shall ide services to be provious: (1) The services of resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as app	appropriately trained staff entify and document the vided by the facility, as stered to the individual appropriate to the:  Iffered shall be reviewed propriate and discussed by acility as needs or desires					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155816	B. W	ING		03/26/	/2015
NAME OF A	NOT A DELL'A CONTROLLER	<u></u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	•		1635 N	ARLINGTON AVE		
	TON PLACE HEAL				IAPOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		e facility or the resident		TAG	BEI TELEXCT,		DATE
	may request a se						
		oon service plan shall be					
	•	by the resident, and a					
		e plan shall be given to the					
	resident upon req						
	· '	on and documentation of is needed if evaluations					
	· ·	initial evaluation indicate					
	no need for a cha						
		on of medications or the					
		ential nursing services, or					
		a licensed nurse shall be ication and documentation					
	of the services to						
		lew and record review,	R 2	17			04/25/2015
		d to ensure a Resident			R 217		
	1	vice Plan. This affected					
	_	reviewed for service					
	plans (Resident						
	plans (Resident)	т <b>о</b> ).					
	Findings include	2.			Corrective actions		
					accomplished for those residents found to be affected	ام	
	The clinical reco	ord for Resident #8 was			by the alleged deficient	;u	
	reviewed on 3/2	6/15 at 11:45 a.m. The			practice: Resident #8 has a		
	diagnoses for Re	esident #8 included, but			signed service plan in place.		
	_	to, congestive heart					
		mellitus, and chronic					
	obstructive pulm				Identification of other reside	nts	
	, seemed pain	y			having the potential to be		
	The Service Plan	ns for Resident #8, dated			affected by the same alleged	l	
		15, did not indicate a			deficient practice and		
	signature for Re				corrective actions taken: DH		
	signature for Re	Siuciil #0.			or designee will review all serv		
	Duning and interes	vious with the Director of			plans to ensure they are signed by the resident and/or	:u	
	_	view with the Director of			representative.		
		(DHS), on 3/26/15 at					
	12:15 p.m., she	indicated Service Plans			Measures put in place and		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/26/2015
	PROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE I ARLINGTON AVE NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	of Attorney/Respon them.  On 3/26/15 at 1: Support Clinicia facility was not a Service Plan for  A policy titled, Cand Service Plan received from the p.m. The policy	Guidelines for Evaluation a, dated 10/12, was e CSC on 3/26/15 at 2:15 indicated, "4. The esponsible party should		systemic changes made to ensure the alleged deficient practice does not recur: Dror designee will re-educate the Licensed Nurses on the following guidelines: Evaluating and Service Plan.  How the corrective measure will be monitored to ensure alleged deficient practice do not recur: The following au and for observations for 5 residents will be conducted both DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to encompliance: Review service plans to ensure they are sign by the resident and/or representative.	HS ne wing on  es the pes dits  y the nsure
R 240 Bldg. 00		Deficiency and assistance with ving, shall be provided		The results of the audit observations will be reported reviewed and trended for compliance thru the campus Quality Assurance Committe a minimum of 6 months then randomly thereafter for further recommendation.	e for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			COMPLETED	
		155816	B. W	ING		03/26/2015	
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	_
NAME OF P	ROVIDER OR SUPPLIER			1			
ADLING		TH CAMPILE			ARLINGTON AVE		
ARLING	ON PLACE HEALT	H CAMPUS		INDIAN	IAPOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Based on intervi	ew and record review,	R 2	40	R 240 Corrective actions	04/25/2015	
	the facility failed	l to follow a Physician's			accomplished for those		
	_	need for weekly weights			residents found to be affecte	ed .	
					by the alleged deficient		
	for 1 of 5 resider				practice: Resident #8 - revie		
	Physician's Orde	ers (Resident #8).			to ensure weights are obtained		
					ordered. Identification of otl		
	Findings include	:			residents having the potential	al	
					to be affected by the same		
	The clinical reco	ord for Resident #8 was			alleged deficient practice and		
					corrective actions taken: DH	łS	
		5/15 at 11:45 a.m. The			or designee will review all		
	diagnoses for Resident #8 included, but				residents with weight monitoring	<u> </u>	
	were not limited	to, congestive heart			to ensure they are obtained as	š	
	failure, diabetes	mellitus, and chronic			ordered. Measures put in		
	obstructive pulm				place and systemic changes made to ensure the alleged		
	oostractive pann	ionary discuse.			deficient practice does not		
	Th. F.1	15 Db			recur: DHS or designee will		
		15 Physician's Order			re-educate the Licensed Nurse	es	
		er for weekly weights and			on the following guideline:		
	to notify the Phy	sician of a 5 pound gain			Evaluation and Service Plan		
	in a week. The	order was initiated on			How the corrective measures	s	
	11/1/14.				will be monitored to ensure t		
					alleged deficient practice do	es	
	The following	aights ware not leasted			not recur: The following audit		
	_	eights were not located			and /or observations for 5		
	in the clinical red	cora:			residents will be conducted by	' the	
	2/5/15,				DHS or designee 2 times per		
	2/12/15, &				week times 8 weeks, then		
	2/19/15				monthly times 4 months to ens		
					compliance: Review residents	l l	
	Resident #8's Sa	rvice Plans, dated			with weight monitoring to ensure they are obtained as ordered.	ле	
					The results of the audit		
		15, indicated to weigh			observations will be reported,		
	per orders.				reviewed and trended for		
					compliance thru the campus		
	During an interv	iew with the Clinical			Quality Assurance Committee	for	
	_	n, on 3/26/15 at 1:50			a minimum of 6 months then		
	* *	ed the facility was unable			randomly thereafter for further		
	p.m., she mulcat	cu me facility was ullable			1	ı	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/26/2015
	PROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE JAPOLIS, IN 46218	3
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	#8.  A policy titled, C and Service Plan received from C p.m. The policy service plan shall	Guidelines for Evaluation a, dated 10/12, was SC on 3/26/15 at 2:15 indicated, "6. A Il be identified and response to the resident's		recommendation.	
R 298 Bldg. 00	(2) A consultant p employed, or undo (A) be responsible in 856 IAC 1-7; (B) review the dru practices in the fa (C) provide consu procedures of ord administering, and well as medication (D) report, in writin his or her designed dispensing or adm (E) review the dru	ervices - Deficiency harmacist shall be er contract, and shall: e for the duties as specified g handling and storage cility; Itation on methods and ering, storing, d disposing of drugs as			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	<u> </u>			COMPLETED
		155816	B. WI	NG		03/26/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1635 N	ARLINGTON AVE	
ARLING <sup>-</sup>	TON PLACE HEALT	TH CAMPUS			IAPOLIS, IN 46218	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	Ī	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	<del> </del>	ew and record review,	R 29		R 298 Corrective actions	04/25/2015
		d to ensure a pharmacist	1 1 2	,0	accomplished for those	04/25/2015
	1	•			residents found to be affecte	d
		dent's drug regimen at			by the alleged deficient	
	_	sixty days. This had the			practice: Resident #8 -	
	potential to affect	et 1 of 5 residents			pharmacist has reviewed the o	-
	reviewed for pha	armacist review (Resident			regimen. Identification of ot	
	#8).				residents having the potentia	al
					to be affected by the same	
	Findings include	<u>.</u>			alleged deficient practice and	
	l mamga meraut	•			corrective actions taken: DH or designee will review all	5
	The clinical reco	ord for Resident #8 was			residents to ensure the	
					pharmacist has reviewed the o	drua
	reviewed on 3/26/15 at 11:45 a.m. The				regimen in the past 60 days.	
	_	esident #8 included, but			Measures put in place and	
		to, congestive heart			systemic changes made to	
	failure, diabetes	mellitus, and chronic			ensure the alleged deficient	
	obstructive pulm	nonary disease.			practice does not recur: DHS	S or
					designee will re-educate the	:
	A Pharmacist Re	eview for Resident #8			Licensed Nurses on the follow guideline: Pharmacy Guideline	_
	was not located	in the clinical record.			How the corrective measures	
					will be monitored to ensure t	
	During an interv	riew with the Clinical			alleged deficient practice do	-
	_	in (CSC), on 3/26/15 at			not recur: The following audits	
					and /or observations for 5	
	* '	ndicated the facility was			residents will be conducted by	the
		Pharmacist Review for			DHS or designee 2 times per	
		eptember 2014 and			week times 8 weeks, then monthly times 4 months to ens	NUTO
	January 2015. A	A Pharmacist Review was			compliance: Review residents	
	not located for the	he month of November			ensure the pharmacist has	
	2014.				reviewed the drug regimen in t	the
					past 60 days. The results o	f
	A policy titled. F	Pharmacy Guidelines,			the audit observations will be	
	1 2	is received from the CSC			reported, reviewed and trende	
	· · · · · · · · · · · · · · · · · · ·	55 p.m. The policy			for compliance thru the campu Quality Assurance Committee	
					a minimum of 6 months then	101
		The campus pharmacy			randomly thereafter for further	
	consultant shall	review the resident's			Indicated to facilities	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 03/26/2015
	ROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		ne every 60 days"		recommendation.	
R 410 Bldg. 00	completed within the admission or upon forty-eight (48) to a The result shall be induration with the and by whom admit (f) For residents with documented negation result during the pince months, the baselishould employ the first step is negative be performed with weeks after the first repeat testing will infection with tube (g) All residents with the tuberculin site to have a chest x-information with the state of the tuberculin site of tuberculin sit	Noncompliance uberculin skin test shall be hree (3) months prior to a admission and read at seventy-two (72) hours. a recorded in millimeters of a date given, date read, ainistered and read. ho have not had a tive tuberculin skin test receding twelve (12) ine tuberculin skin testing a two-step method. If the ive, a second test should in one (1) to three (3) set test. The frequency of depend on the risk of			
	the facility failed skin test was con admission for 1 d	ew and record review, I to ensure a tuberculin npleted on/or prior to of 7 resident's records erculin testing. (Resident	R 410	R 410  Corrective actions	04/25/2015
	#17) Findings include	• .		accomplished for those residents found to be affected by the alleged deficient practice: Resident #17 has a	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ЛLDING	<u>00</u> COMPLETED		
		155816	B. W	ING		03/26/	2015
	PROVIDER OR SUPPLIEF			1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
TAG	The clinical recoreviewed on 3/20 Resident #17 was The diagnoses for but were not lim dementia, cerebilleft side hemipara.  A document title Record" indicates a tuberculosis sk was read on 2/13	ed, "Immunization ed Resident #17 received tin test on 2/11/15, and it 8/15. On 2/19/15,		TAG	current tuberculin skin test documented.  Identification of other resider having the potential to be affected by the same alleged deficient practice and corrective actions taken: DH or designee review all resident to ensure a current tuberculin skin test is documented.	IS ts	DATE
	2/22/15.  An interview wa Clinical Support 1:45 p.m. She in provide informa #17 was given a	as conducted with the Clinician on 3/26/15 at adicated she could not tion in which Resident first or second step a test on or prior to			Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS designee will re-educate the Licensed Nurses on the follow campus guidelines: Assisted Living Guideline Chest X-Ray Mantoux Testing	ing	
	A policy titled, 'Guidelines Ches Testing" was proposed p.m. by the Clin the following: residents are free admission. Proceshould have a M protein derivative	·			How the corrective measures will be monitored to ensure talleged deficient practice do not recur: The following audits and /or observations for 5 new admission residents will be conducted by the DHS or designee 2 times per week tim 8 weeks, then monthly times 4 months to ensure compliance: Review new admission reside to ensure a tuberculin skin te was completed and document on/or prior to admission.	he es s nes ents st	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE CO A. BUILDING B. WING		ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER  ARLINGTON PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	previous testing	or upon admission			The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee a minimum of 6 months then randomly thereafter for further recommendation.		

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